Wisconsin Initiative to Promote Healthy Lifestyles

Final Progress Report
to the Substance Abuse and Mental Health Services Administration
SBIRT Grant TI-18309
August 2012

Wisconsin has a drinking problem. Alcohol use is widespread in the culture and Wisconsin often leads the nation in risky drinking with the related consequences.[1] Yet state residents show one of the lowest risk perceptions for binge drinking in the U. S.[2] In 2006 the State of Wisconsin Department of Health Services (DHS), Division of Mental Health and Substance Abuse Services (DMHSAS) was awarded a 5-year Screening, Brief Intervention, and Referral to Treatment (SBIRT) Grant by the U. S. Substance Abuse and Mental Health Services Administration (SMAHSA) to make a difference. This report summarizes the accomplishments, outcomes, challenges, and lessons learned. First, a brief description is provided of the Grant's overarching structure and mission. Next, the outcomes of Grant goals are described. And finally, accomplishments and lessons learned are summarized. Information in this report will be supplemented by more substantive content and analysis which can be found in the supporting Attachments (see Appendix).

Project Overview

Grant Structure

The Grant, entitled the Wisconsin Initiative to Promote Healthy Lifestyles (WIHPL), comprised several organizational partners that served specific roles and functions. The DHS through DMHSAS provided the Director and SBIRT Program Coordinator. The function of DMHSAS was to provide contract management, which included budget, funding, and administrative oversight to ensure Federal reporting and compliance obligations. Contracting for the provision of specialist substance abuse treatment was also provided through DMHSAS. The University of Wisconsin's Department of Family Medicine (DFM) provided the Clinical Director, Project Manager, and Manager of Site Operations. The Wisconsin Medical Society (known as the Society) housed the Grant's Coordinating Center and provided the Office Manager, Treatment Liaison, Director of Cultural Competence, and Manager of IT Services. The Society recruited all clinical sites for participation in the Grant and contracted with most to deliver SBIRT services; DHS contracted with the remaining sites. The DFM and Society staff provided coordination, management, and oversight of all clinical activities. The University of Wisconsin Population Health Institute served as the evaluator with a team including the Director of Evaluation, Evaluation Manager, and several Research Specialists.

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[1] Wisconsin Department of Health Services, Division of Public Health and Division of Mental Health and Substance Abuse Services. Wisconsin Epidemiological Profile on Alcohol and Other Drug Use, 2010 (P-45718-10). November 2010. Accessed from http://www.dhs.wisconsin.gov/substabuse/docs/spfSig/2010Profile.pdf

[2] Substance Abuse and Mental Health Services Administration. Wisconsin: States in Brief: Substance Abuse and Mental Health Issues At-A-Glance. Accessed from http://www.samhsa.gov/statesinbrief/2009/WISCONSIN_508.pdf

Mission Statement

WIPHL's mission was to improve the lives and health of Wisconsin residents by providing early substance use screening and intervention and by making SBIRT a part of routine care in primary healthcare. WIPHL's policy goal was to support and improve the systematic delivery of SBIRT targeting a variety of risky and unhealthy behaviors and mental health disorders in health care settings. This involved forging partnerships among the federal, state, tribal, county, and local governments, health care financing organizations, health care provider organizations, health care professionals, mental health providers, employers, substance abuse treatment providers, and patients.

Goals and Outcomes

WIPHL had nine goals in this Grant. In this section, each goal is identified followed by a description of outcomes and accomplishments.

Goal 1: WIPHL will assemble the organizational infrastructure to support SBIRT implementation, ongoing improvement, evaluation, and policy change.

- Clinical sites involved in the grant assembled an implementation team including the clinic manager, physician provider, supervisor, SBIRT champion, and the Health Educator who was responsible for the delivery of SBIRT services. A communications infrastructure was developed to provide information, updates, resources, and motivation for the teams to implement SBIRT services with fidelity. The teams attended the annual or semi-annual statewide meetings, received the Grant's monthly newsletter called *WIPHL Word* (see **Attachment 1** for a sample issue) for regular project updates, and stayed in regular contact with the WIPHL Coordinating Center via email and phone. Exit interviews with team members upon completion of their involvement in the Grant showed a high level of satisfaction for participation in the WIPHL program.
- Billing and reimbursement of services is a critical element of sustainable SBIRT implementation. In January 2010 Wisconsin Medicaid (MA) activated SBIRT billing codes to provide reimbursement to pregnant women and all enrolled patients ages 10 and up. The SBIRT benefit is described in MA's monthly *Forward Health Update* (see **Attachment 2**). The MA policy provided for "effective reimbursement" which WIPHL defined as: 1) reimbursement under national billing codes, 2) no out-of-pocket payments by patients, 3) reimbursement for paraprofessional-administered SBIRT, and 4) reimbursement when paraprofessionals and other providers deliver SBIRT and other services at the same visit. WIPHL created the *SBIRT Coding, Billing, and Reimbursement Manual* to educate clinical sites and providers (see **Attachment 3**). During Grant Year 4, seven sites initiated billing for services and participated in WIPHL's Claims Submission Tracking Program. Data from the sites showed that of 866 claims submitted, 516 (60%)

were paid satisfactorily, 11 were paid but at an amount that clinics found unsatisfactorily, and 342 were denied. Based on actionable data for denied claims, Dr. Richard Brown, the WIPHL Clinical Director, contacted medical directors to appeal and resolve denials. Wisconsin MA requires its managed care organizations to reimburse for SBIRT and WIPHL notified the MA Compliance Officer to identify which managed care organizations denied SBIRT claims. By the end of the Grant, 19 commercial health insurance organizations reimbursed at least one SBIRT claim each.

- When the SBIRT codes were activated in January 2010, MA required that to deliver SBIRT services and receive reimbursement, licensed providers must complete 4 hours of training and non-licensed providers must complete 60 hours of training (at least 30 hours face-to-face). WIPHL developed an interactive web-based SBIRT training for licensed providers and developed the 60 hour training curriculum incorporating best practices in adult learning.
- When MA activated the SBIRT codes, Wisconsin DHS simultaneously authorized a range of MA providers to bill for SBIRT services, including crisis intervention workers and prenatal care coordinators (PNCCs). Results of a 60 hour pilot training for non-licensed crisis workers (N = 19) and PNCCs (N = 16) showed that training of these professionals in SBIRT was feasible. There now exists the potential for delivery of SBIRT services with at-risk populations who present in settings beyond primary care. However, a 2 month follow-up interview via phone showed that all participating agencies, except for one, had not implemented services suggesting that technical assistance beyond intensive training will be needed if agencies are to successfully integrate SBIRT into practice.
- There is a business case to be made for the delivery of SBIRT as described in Quanbeck, A., Lang, K., Enami, K., & Brown, R. L. (2010). A cost-benefit analysis of Wisconsin's Screening, Brief Intervention, and Referral to Treatment: Adding the employer perspective. *Wisconsin Medical Journal, 109*(1), 9-14. To promote demand of SBIRT services among purchasers of healthcare, WIPHL developed a partnership with the business community. WIPHL worked with the Wisconsin Manufacturers and Commerce (WMC; the state's business association) to request that their health plans reimburse for SBIRT services. WMC now recommends that all employers request that their health plans reimburse for SBIRT and that their providers deliver SBIRT. WIPHL reached over 150 employers through a series of regional meetings and presentations at Chambers of Commerce. The Business Health Care Group (BHCG) of Southeastern Wisconsin, Wisconsin's largest employer healthcare purchasing cooperative, will require in 2013 that its providers begin delivering alcohol, drug, tobacco, and depression screening and intervention services. BHCG serves 100 employers and purchases healthcare for 200,000 individuals in eastern Wisconsin. To help raise the profile of SBIRT among the business community, the website Health Plans for Behavioral Screening and Intervention was launched in 2011. Co-sponsored by WIPHL, the Medical Society, WMC, BHCG and The Alliance, a Madison-area business health care group, the website listed

Wisconsin payers who offer effective reimbursement for SBIRT. In the *Service Design Site Visit Report* by JBS International, Inc. and Alliance for Quality Education, Inc., the federal evaluation team noted that, "Wisconsin's effort to sustain SBIRT services could serve as a model for State programs moving forward. The clinical director, Dr. Richard Brown, and WIPHL staff have worked diligently to construct a business case for sustainability and generate momentum around commercial, Medicaid, and Medicare reimbursement. This is evident in their creative efforts to engage payers on multiple fronts..."

- WIPHL developed partnerships with key provider organizations to advance the support, dissemination, and sustainability of SBIRT. The Wisconsin Medical Society (known as the Society) provided the coordination home of the Grant. With its statewide reach into the physician community, the Society worked with WIPHL to accomplish several things: a resolution was passed advocating the systematic delivery of and reimbursement for SBIRT; physicians at WIPHL clinical sites were offered up to 20 continuing medical education credits for practice improvement activities; and delivery of SBIRT was integrated into three existing physician continuing medical education curriculums: breast cancer screening, colorectal cancer screening, and bi-polar disorder screening. WIPHL also worked with the Wisconsin Primary Health Care Association to maintain a high profile of SBIRT among federally qualified health centers.
- WIPHL partnered with DMHSAS and the State Committee on Alcohol and Other Drug Abuse (SCAODA) to raise the profile of SBIRT across state government. Implementing SBIRT in primary care is now one of 10 "pillar objectives" in the state's strategic health plan, *Healthiest Wisconsin 2020.* In March 2012, SCAODA introduced a motion stating "that the Council affirm the value of the Screening, Brief Intervention, and Referral to Treatment (SBIRT) project and agree to a closer examination of its implementation." This motion was followed by the creation of an SBIRT Ad Hoc Committee. With the charge to "present recommendations (to SCAODA) regarding future funding for SBIRT and to present recommendations regarding additional implementation strategies" this Committee will continue beyond the Grant to focus on providing a favorable policy environment for the implementation of SBIRT.
- The profile of SBIRT was also raised among the specialist substance abuse treatment community. Historically disconnected, WIPHL enhanced networking and connections between the primary care and specialty treatment settings. Trainings, meetings, and many discussions were facilitated which brought the two communities together to identify barriers and brainstorm ways to enhance the connection between identifying likely substance dependent patients in the primary care setting and providing referral to treatment. "SBIRT" is now listed as a referral source option in the Human Service Reporting System, the state's data monitoring system for all publicly-funded substance abuse treatment providers.

- As part of the Grant, the Governor's Policy Steering Committee met regularly with a membership comprising key leaders and influencers from relevant systems and communities. At the end of the Grant, a new committee called the WIPHL Advisory Council was formed to continue policy-level work with representatives from business, medicine, public health, university research, health insurance, and state government.
- Following the Grant, DMHSAS made the SBIRT Program Coordinator position permanent. Continuing the position beyond the Grant will keep the focus on SBIRT dissemination, demand promotion, and training activities at the state level. There are already multiple requests for SBIRT training from provider organizations.
- A recently redesigned WIPHL website (http://www.wiphl.org/) continues to provide a clearinghouse of information for healthcare professionals, employers, insurers, and advocates.
- A small but growing literature points to SBIRT services significantly reducing patient healthcare costs. To examine this possibility in Wisconsin, the WIPHL evaluation team began an economic analysis of MA patient outcomes for those who received SBIRT services in WIPHL clinics compared to MA patients who had not received services in matched clinics. The goal of this study is to provide information on the real-world costs and economic benefits of SBIRT services in healthcare settings. The results of this study will help inform policies regarding the future MA financing of SBIRT.

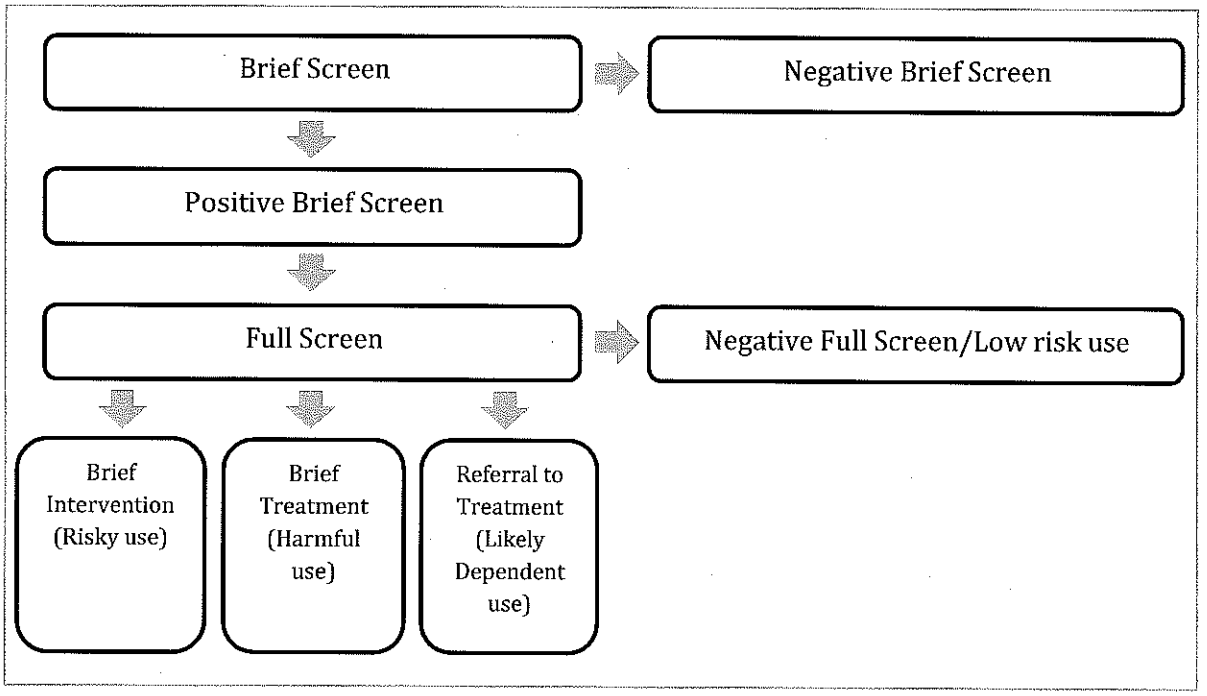
Goal 2: Clinical staff in WIPHL participating sites will demonstrate knowledge and competence to perform brief substance abuse screening with the aid of computer prompts or written questionnaires.

The WIPHL screening protocol began with a brief screen consisting of 4 items to quickly ascertain if a patient had recent (past three month) experiences with alcohol or drugs. The brief screen was typically administered via written questionnaire by reception staff at patient check-in. A medical assistant then reviewed and scored it. If one or more items were endorsed the screen was considered "positive" and the WIPHL clinical staff person was altered to continue the screening process while the patient waited to be seen by the primary care physician in the examination room.

Positive brief screens were followed by the administration of a full screen to further explore the patient's substance use and to identify level of risk. The full screen comprised the evidence-based ASSIST (Alcohol, Smoking, and Substance Involvement Screening Test) instrument. Tablet computers were used by WIPHL clinical staff to guide the delivery of the full screen and subsequent services. Each tablet was programmed with the following: 30 items of the ASSIST related to alcohol, tobacco, and illicit drug consumption and consequences; items related to patient exercise, diet, and health behaviors; required GPRA (Government Performance Results Act) items; and prompts for delivering the planned service that followed screening. The tablet

programming used an algorithm to interpret ASSIST results according to an individual's substance use risk level: low risk use, risky use, harmful use, or likely dependent use. Then, prompts were provided to guide the delivery of the corresponding planned service: brief intervention, brief treatment, or referral to treatment. The flow of service from brief screening to the planned service is shown in **Figure 1**. Tablet programming used skip logic to maximize efficient service delivery and GPRA data collection so that items would not be asked redundantly. Time was of the essence as WIPHL clinical staff often had no more than 10 to 15 minutes with a patient to complete the full screen and the planned service.

Figure 1. WIPHL service delivery workflow.



During an initial one-week training, WIPHL clinical staff received instruction about the continuum of use severity and patient substance use risk levels, how to administer and interpret brief and full screens, how to use the tablet computers to guide service delivery, how to upload patient data to the centralized WIPHL data base, and how to protect patient confidentiality. At the conclusion of training, staff was tested on these knowledge areas with written and practical exams. All staff passed the written knowledge exam. In the practical exam, each staff used their newly assigned tablet to administer the full screen with a simulated patient, then conducted the subsequent planned service. Staff received individualized performance-based feedback from the trainer on their use of the tablet. Following training, the Manager of IT Services and the evaluation team worked closely with clinical staff to maintain the tablets and to ensure integrity of the data.

Goal 3: WIPHL trained health educators will demonstrate the knowledge and competence to deliver computer-prompted, protocol-driven, culturally competent, standardized SBIRT services. The delivery of Health Education services will be based on the trans-theoretical model of behavior change and principles of motivational interviewing.

A central feature of the WIPHL service delivery model was expanding the healthcare team to include a dedicated paraprofessional who delivered the full screens, provided brief interventions, and initiated any referrals to treatment. WIPHL called these staff "Health Educators" because that title carries respect and professionalism, helps frame alcohol and drug use as health issues, and does not carry any legal requirements in Wisconsin. During the Grant, 52 Health Educators were hired and trained. In terms of educational background, 12 (23%) were master's level counselors or social workers, 33 (63%) were bachelor's level, and 2 (4%) were high school graduates with special language or cross-cultural skills; educational background was not listed for 5 (10%); almost all came to WIPHL without prior work experience in substance abuse prevention or treatment.

The training curriculum evolved during the 5-year Grant to reflect advances in training and understandings of SBIRT. By Year 4, training included the following components:

- *Pre-training*. Prior to on-site training, each Health Educator uploaded from the WIPHL website and viewed videos which introduced the WIPHL program and the rationale for SBIRT. Additionally, each was sent via postal mail Rosengren's (2009) *Building Motivational Interviewing Skills: A Practitioner Workbook* and Health Educators completed assigned readings and written exercises. Anecdotally, it was found that the pre-training work greatly prepared Health Educators to understand the basic concepts, spirit, and skills of Motivational Interviewing.
  Initial one-week training. The on-site training focused on building essential knowledge and skills for service delivery (see **Table 1**). Knowledge included the rationale for SBIRT, workflow, use of the tablet computer, and information about alcohol, drugs, addiction, and treatment. Learning Motivational Interviewing (MI) was a primary focus of training as this was the evidence-based practice that grounded the delivery of services. MI comprises a spirit, or way of being with patients (Collaborative, Evocative, Supportive of Autonomy), a skill-set (OARS: Open questions, Affirmation, Reflection, Summary), and strategies to elicit and reinforce patient change talk. Training helped Health Educators to recognize patient language cues suggestive of a particular stage of change such as reasons to continue using a target substance (sustain talk, pre-contemplation), reasons both for and against change (ambivalence, contemplation), and readiness, desire, need, or commitment to change (preparation). The intensive one-week training included lecture, discussion, and many small group and dyad experiential

exercises to build skills. Average ratings of usefulness of this training by Health Educators were moderate to high (see *Final Program Evaluation*, **Attachment 4**, p. 22).

Table 1. SBIRT Knowledge and Skill Domains for Health Educators.

Knowledge Domains	**Description**
• Rationale for SBIRT	Theory, research, and practice basis for screening and brief intervention
• Overview of service delivery	Workflow including universal screening, protocol-driven brief intervention, data collection and quality assurance measures, practice improvement processes, and contractual requirements
• Motivational Interviewing	Introduction to MI key concepts (motivation, ambivalence, righting reflex), Spirit, Skills, and Strategies for eliciting patient change talk
• Stages of Change	Via language cues, identify each patient as pre-contemplating, contemplating, preparing, acting upon, or maintaining change on a particular substance
• Cultural competence in health care	Attention to developing cultural awareness, knowledge, skill, encounters, and desire to learn
• Use of tablet computer	Use of the technology, uploading patient data, patient confidentiality
• Documentation	Required elements of documentation in the patient medical record for reimbursement
• Primer on alcohol and drugs	Prevalence and description of commonly used substances; continuum of severity; risk factors; definitions of substance use disorders and addiction
• Specialty addiction treatment	Modalities, referral process, and payment; medication assisted therapy and types of pharmacotherapy available to appropriate WIPHL patients.
Skill Domains	
• Administer Screening	Administering, scoring, and interpreting results of ASSIST instrument via tablet
• Provide feedback on Screening	Providing screening results, feedback on level of substance use risk, and recommendations using the Elicit-Provide-Elicit MI procedure
• Deliver Brief Intervention	Using computer-assisted Brief Intervention protocol; recognizing, eliciting, and reinforcing patient change talk and motivation for change using MI Skills
• Develop change plan	Collaboration with the patient to develop a concrete change goal, including identifying barriers and supports
• Initiate Referral to Treatment	Identification of patients who are likely dependent; initiating a conversation using MI to explore interest and motivation for treatment entry; patient linkage to local resources
• Respond to special circumstances	Using MI as a person-centered practice to handle specific patient concerns and risk behaviors

- *On-going learning*. Following the initial one-week training, all WIPHL Health Educators participated in a weekly conference call facilitated by the Manager of Site Operations. The focus of the call was to address implementation issues and provide accountability on quality improvement projects. Individualized phone consultation was also provided to Health Educators, as needed. All participated in quarterly retreats to continue building MI skills, to recognize and celebrate successes, and to initiate quality

improvement projects. Average usefulness ratings of these retreats made by Health Educators were moderate to high (see **Attachment 4**, p. 23).

At the conclusion of the initial training, Health Educators took a written exam to test knowledge and a practical exam to test skills. All Health Educators passed the written exam. The practical exam had each Health Educator conduct screening using the tablet and a brief intervention using MI. Although Health Educators demonstrated an adequate delivery of screening and understanding of the brief intervention protocol, not a single Health Educator was able to demonstrate basic proficiency in Motivational Interviewing. This finding is consistent with the MI training literature which shows that "one shot" training experiences are insufficient to promote even a basic level of proficiency in MI.

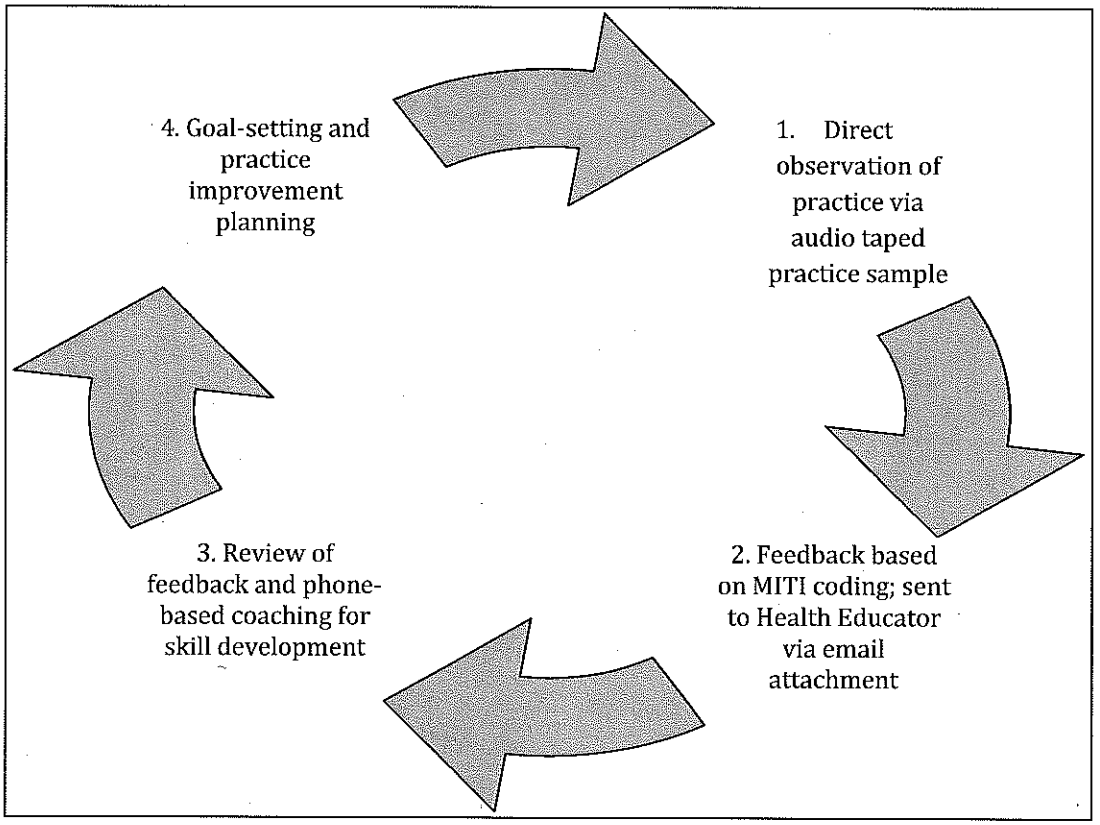
WIPHL developed a robust process [3] for Health Educators to continue learning MI following initial training (see **Figure 2**). Every month, Health Educators submitted an audiotaped SBIRT practice sample via postal mail to the Manager of Site Operations. Patient consent was obtained for all tapes and Health Educators were provided self-addressed stamped mailers. Because completion of monthly tapes was a contractual requirement, there was a high rate of compliance for tape submission. During Grant Years 4 and 5, Health Educators submitted 277 audiotapes. Each tape was transcribed by a contractor, then using the audio and transcript, WIPHL training staff used the Motivational Interviewing Treatment Integrity (MITI) instrument to code practice samples. On the transcript, the trainer identified Health Educator use of MI skills and any patient change talk, as well as MI non-adherent behaviors such as providing information to the patient without first asking permission, advising, warning, or confronting. Global ratings for MI spirit were made on the 1(low) to 5(high) scales provided by the MITI. Once coding was complete, the skill behavior counts and global spirit ratings were entered into a spread sheet template (see **Attachment 5**) and a graphic depiction of the session provided feedback as to how the Health Educator's use of MI compared to established benchmarks for basic proficiency as defined in the MITI. The graph and coded transcript was sent to the Health Educator via email attachment, then during a scheduled 45 to 60 minute phone call, results were reviewed, coaching on skills was provided, and performance goals were set for the next month. During the phone call, the WIPHL trainer modeled the use of MI.

Health Educators struggled to learn MI and ample resources were dedicated to monitoring, feedback, and coaching to assist with skills acquisition. This allocation achieved successful results. Of the 18 Health Educators involved during the two years of this learning process, all were able to demonstrate basic proficiency in at least one taped practice sample. Those who demonstrated basic proficiency in three practice samples were allowed to reduce tape submission from monthly to quarterly. By the end of the Grant, most Health Educators had

[3] Learning process based on Martino (2010), Miller et al. (2004), and Rosengren (2009).

successfully "graduated" to the lower monitoring status. A quantitative analysis of MITI scores provided by Denise Ernst, a MITI expert at the University of New Mexico, showed significant improvement over time in average Health Educator MI spirit and skills scores.

Figure 2. Motivational Interviewing learning process for Health Educators.



Cultural competency also grounded the delivery of SBIRT services. WIPHL patients who received the brief screen reflected a diversity of gender, race, and age: 63% were female; 58% were white and non-Hispanic, 15% were Hispanic, 14% were black or African American, 11% were Native American, 1% were Pacific Islander, and 2% were multiracial; 15% were ages 18 to 24 years, 23% were ages 25 to 35 years, 50% were ages 36 to 64 years, and 12% were 65 years or older. As opposed to taking a "trait" approach to cultural competency – which stresses learning a list of attributes of various ethnic groups based largely on generalizations – WIPHL took an "ethnographic-style" approach which included developing cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire.[4] Training focused on helping Health Educators to see the diversity within each demographic group rather than the differences between groups. Health Educators built cultural knowledge and skills, along with the flexibility and self-awareness needed to work with people from diverse backgrounds.

[4] Cultural competency framework by Campinha-Bacote and colleagues (Campinha-Bacote, 2002; Campinha-Bacote & Munoz, 2001).

Moreover, because it can be hard to see the cultural dimensions of one's own group, considerable time was spent examining the normative use of alcohol and acceptance of binge drinking as aspects of "Wisconsin culture." The goal was to advance cultural competency while emphasizing that Health Educators take a learning stance in which the patient was the expert and the provider engaged in a mutual inquiry and collaborative approach to change. The integration of cultural competency with MI greatly enhanced Health Educators' ability to work successfully with diverse patients on a wide range of behavioral health concerns.

In exit interviews conducted by the evaluation team, most Health Educators reported that they had received an adequate amount of training, support, and technical assistance to do their job effectively (see **Attachment 4**, p. 25).

Goal 4: WIPHL will implement substance abuse brief screening and SBIRT services at primary care settings in urban, suburban, and rural Wisconsin for a target number of individuals over the five year Grant period.

WIPHL recruited clinical sites through networking and selected them for their diversity in geographic location, population density, payer mix, and their readiness to implement SBIRT. A total of 33 clinical sites participated. Of these sites, nine were located in or near Milwaukee, 10 in or near cities with populations of 30,000 to 250,000, and 14 in rural areas. The sites included 17 large commercial primary care or multispecialty groups, six federally qualified health centers or look-alikes, five independent commercial primary care sites, two Tribal health centers, a health department clinic, a hospital-based emergency department, and a hospital trauma center and inpatient unit. Each site was as unique as the population it served. For example, clinical sites were located in large inner city settings as well as in rural settings in which facilities had special garages for horse-drawn carriages; there were clinics housed in double-wide prefabricated trailers and there were clinics housed in state-of-the-art facilities. (For more details on clinical site participation in WIPHL, see **Attachment 4**, pp. 10-13.)

Between March 2007 and June 2011, there were 166,647 patients eligible to receive SBIRT services. Of these, 113,642 patients (68% of those eligible) completed a brief alcohol and drug screen. A positive brief screen was determined by a patient response of "yes" on at least one of four items. Of those patients screened, 37,335 patients (33%) showed positive results. Following the positive brief screen, 23,407 patients (63%) completed the full screen to more fully assess patientsubstance involvement. (Note: at least an additional 3,141 full screens were completed with patients who either did not have a brief screen or who showed negative brief screen). The full screen (assessment) categorized patient substance use along the continuum of severity with the following results: 19% were low risk users, 67% were risky users, 6% were harmful users, and 8% were likely dependent users. Assuming similarity between screened and unscreened patients, and between patients with positive brief screens who did and did not

receive the full screen, the estimated population prevalence along the continuum of severity is as follows: 73% were abstainers or low risk users, 22% were risky users, 2% were harmful users, and 3% were likely dependent. Given the relatively high prevalence estimate of risky users (22%) among Wisconsin's adult primary care population, continuing to move toward widespread and systematic implementation of SBIRT is clearly warranted. For patients who showed risky or harmful use, 16,082 received a brief intervention and 868 received brief treatment. For those who were likely dependent users, 1,101 patients were asked about their interest in a referral to treatment.

Service targets were revised in 2008 with SAMHSA's approval and WIPHL was required to reach 80% of each established target. How did the service delivery results compare to the targets? As shown in **Table 2**, WIPHL met planned service targets for brief intervention and referral to treatment inquiries. However, WIPHL fell short of the targets for providing screening and brief treatment services (see **Attachment 4**, p. 15)

Table 2. Planned SBIRT service targets and actual number of patients served.

SBIRT Service Component	Planned Service Target (revised 2008)	Number of Patients Served	Percentage of Planned Service Target
Positive Brief Screening and Full Screening	88,425	63,878	72.2%
Brief Intervention	18,957	16,082	84.8%
Brief Treatment	1,304	868	66.6%
Referral to Treatment	1,111	1,101	99.1%

Goal 5: WIPHL will finance conventional, specialty-based substance abuse treatment for 1,111 patients who are referred by WIPHL health educators from general medical settings.

In Wisconsin, as nationally, most specialty-based substance abuse treatment is publicly-funded. Because Federal Substance Abuse Block Grant funding is disbursed to County and Tribal health departments through DMHSAS, DMHSAS contracted directly for the provision of treatment services with those departments in proximity of WIPHL clinical sites. Where services were available and when clinically appropriate, WIPHL patients could be referred to receive residential, outpatient, intensive outpatient, Medication Assisted Therapy, or ancillary Recovery Support Services through the Grant.

Consistent with what other SAMHSA SBIRT state Grantees anecdotally reported, Referral to Treatment (RT) was the most challenging component of SBIRT implementation. Between March 2007 and June 2011, approximately 1,873 likely dependent users were identified across WIPHL clinical sites. Of these patients, 1,101 were asked about a possible referral to treatment – almost 100% of the number of planned inquiries. Yet there was a difference between *asking* patients about a possible referral and actually *referring* patients to treatment. Of those asked, 452 patients were subsequently referred to treatment and 183 patients (10% of all likely dependent users) entered treatment. The relatively low rate of treatment entry (40% of those referred) was somewhat surprising, given that the Grant provided funding for patients who could not otherwise afford it. However, barriers to entry are many and well documented, including wait lists, work schedules, child care, transportation, access to culturally competent and gender-specific treatment, access to treatment in one's native language, motivation, and low risk perception or lack of perceived need for treatment.

The Health Educators' task for RT was to ask likely dependent patients if they were interested in a possible referral to treatment. For those interested, the Health Educator informed the WIPHL Treatment Liaison and this member of the Coordination Center followed up with the prospective patient. WIPHL developed a materials packet to facilitate RT: semi-structured interview to ascertain pertinent patient referral information; protocol to guide the referral process; a *SBIRT Patient Referral Form*; and a *SBIRT Referral Outcome Reporting Form* (see **Attachment 6**). The Treatment Liaison used MI to engage patients in a collaborative and goal-oriented discussion about entering treatment. Every effort was made to match a patient's needs, preferences, schedules, and financing options with programs and available treatment slots.

There were advantages and disadvantages to having the Treatment Liaison as a dedicated position. Advantages were that a provider directory and network was developed to locate referral options. Moreover, to access services, patients must navigate a fairly complex bureaucratic system and the Treatment Liaison was able to assist patients in this process. However, the primary disadvantage was that Treatment Liaison involvement may have inadvertently created an extra barrier: a two-step process in which the Health Educator referred to the Treatment Liaison, then the Treatment Liaison referred to treatment provider. With the switch from working with the familiar Health Educator to the unfamiliar Treatment Liaison, many patients may have lost interest or momentum to enter into treatment services. Presumably, at least for some patients, the change in contact person became an opportunity to disengage from the referral process.

An alternative RT model was for the Health Educator to directly refer to the treatment provider. One outstanding example of this was demonstrated at a Tribal health center. The

center had its own behavioral health program (located in a nearby facility) and referrals were seamless between the Health Educator providing SBIRT in the primary care setting and the treatment provider working in the behavioral health setting. The involvement with WIPHL allowed this site to better coordinate its primary care and behavioral health services.

Goal 6: A major emphasis of the program is to develop, maintain, and continually improve systems that will dependably and sustainably deliver culturally competent SBIRT services. Sustainability will require that each clinic deliver services at a sufficient volume, and with sufficiently documented quality, that payers will reimburse for clinical service provision when such reimbursement is available.

During Grant Year 3 (Summer 2009), the evaluation team conducted a process evaluation of WIPHL and the delivery of SBIRT services based on interviews with 28 staff (including Health Educators, supervisors, and clinic mangers) and an analysis of 8 clinical sites (see *A Process Evaluation of Implementing WIPHL in Primary Care Clinics*, **Attachment 7**). Although the orientation into WIPHL, training, and service delivery was standardized across sites and Health Educators, the evaluation showed a wide variation of outcomes. Several themes and areas for improvement were identified.

- *Lack of clinic buy-in.* Lack of clinic buy-in to WIPHL was a significant barrier to implementing SBIRT. Although some clinics fully integrated their Health Educator as a member of the healthcare team, other clinics did not view their Health Educator as a valued resource. Clinic leadership could become a hindrance to service delivery by directing the Health Educator to other tasks and duties, by not perceiving the value of alcohol and drug screening, or by not viewing primary care as an appropriate setting in which to conduct screening. The lack of acceptance of WIPHL at some clinics likely translated into inefficient and unreliable delivery of screening. WIPHL responded by improving the site recruitment and orientation process. Prospective sites were provided with clear expectations upfront and buy-in from top to bottom was sought. Specifically, the following areas were clearly defined, addressed, and discussed: the importance of alcohol and drug screening; the Health Educator roles and responsibilities; the benefits of SBIRT; program parameters established by SAMHSA; and addressing staff's discomfort about screening for patient substance involvement. Clinic buy-in likely increased as result of these adjustments.
- *Assemble a multidisciplinary healthcare team.* For those sites that did join, WIPHL improved at helping sites to assemble and maintain a multidisciplinary healthcare team. These teams included the physician, clinic manager, nurses, medical assistants, any staff "champions" of SBIRT, and reception. The clinics that achieved the most success were those that fully integrated the WIPHL Health Educator into the team. Teams that met regularly, that were in close contact with the WIPHL Coordinating Center to work through implementation problems, and that provided "warm-

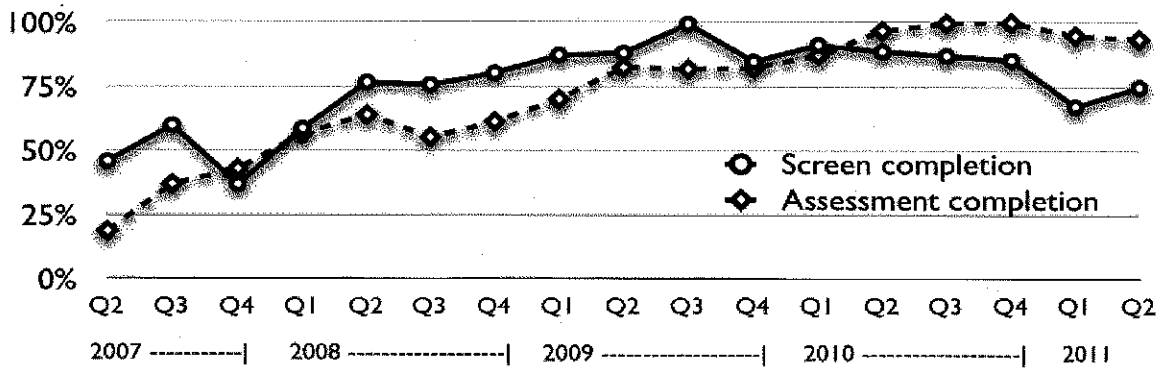
handoffs" from medical staff to the Health Educator were able to greatly improve the rate of brief screening for eligible patients, as well as the rate of full screening for those with positive brief screens. WIPHL improved at helping clinics assemble the team and integrate the Health Educator into it.

- *Hiring of Health Educators.* Successful integration of Health Educators into the healthcare team likely reflected a reciprocal process involving the team's perceptions of the Health Educator and the individual Health Educator's demonstration of specific traits. The process evaluation identified several traits of Health Educators who showed success in carrying out their roles and responsibilities while establishing themselves on the health care team: engaging personalities; proactive, persistent, mission-driven, and thick skinned; flexible and adaptive to clinical workflow; a team player; self-sufficient and independent; good communicators; quick learners and good at gathering information; familiar with the local culture; and compassionate and non-judgmental with patients. WIPHL improved the hiring process by better identifying these traits in prospective Health Educators during the application and interview process, and ultimately, hiring for success.
- *Inconsistent implementation.* There were several barriers to standardizing service delivery (see **Attachment 4**, pp. 14-18). Sites defined "eligible patients" in a variety of ways, individual Health Educators placed emphasis on asking some screening questions but not others, and there were challenges to fully entering required data into the tablet computer. Indeed, as shown in the *Final Outcomes Report* (see **Attachment 8**, p. 8) sites showed a wide range of completion rates for brief and full screens. To address the barriers and to increase standardization, WIPHL improved its monitoring of full screen delivery, provided each clinical site with feedback on rates of completion, emphasized standardization and data collection in on-going Health Educator training, and re-programmed the tablet several times to increase functionality and responsiveness to Health Educator need.
- *Incompatibilities between screening and GPRA data collection, and Motivational Interviewing.* For Health Educators, one of the biggest challenges to delivering services was the incompatibility between the screening and GPRA data collection process (quick succession of impersonal closed-ended questions) and the use of MI (person-centered and evocative). Health Educators reported frustrations with not being able to fully use their MI spirit and skills with the way the tablet was programmed. WIPHL attempted to resolve the incompatibilities through coaching Health Educators on creative ways to utilize MI within the confines of the tablet.

As WIPHL learned how to better select, prepare, and guide clinical sites (see *Clinical Site Guide and Checklist,* **Attachment 9**) and as leaders at established sites learned how to more efficiently deliver SBIRT, screening became more fully integrated into clinic operations. As depicted in

Figure 2, the percentage of eligible patients who completed a brief screen increased over time, as did the percentage of patients with a positive brief screen who completed a full screen (assessment). Linear regressions conducted by the evaluation team showed that quarterly improvements on both measures were significant ($p < .001$). From the second quarter (Q2) of year 2009 through the fourth quarter (Q4) of year 2010, all sites demonstrated completion rates that exceeded 80%. Completion rates fell slightly during the final months of service delivery as established sites left and new sites joined.

Figure 2. Average brief screen and full screen (assessment) completion rates by year.



Of the 33 clinics that participated in WIPHL, 14 clinics (42%) were located in rural areas of the state. In several of these clinical sites, WIPHL found that a full-time Health Educator was not sustainable due to the low patient volume. Telemedicine units were added to selected rural sites to allow service delivery to satellite clinics from a distance. It was discovered that with this technology, a full-time Health Educator could adequately serve the rural hospital and clinic in addition to its satellite clinics.

As participants in the Grant, clinical sites did not have to fund the Health Educator position or incur any related costs to delivering SBIRT. However, if SBIRT is to become a sustainable service, clinics must be able to bill and receive reimbursement for services. After Wisconsin Medicaid activated the SBIRT codes in January 2010, WIPHL provided assistance to sites with billing. During the Grant, 7 sites initiated billing for services and participated in WIPHL's Claims Submission Tracking Program to examine the process of billing and to identify the factors of successful reimbursement.

As a result of improved delivery processes, Health Educators effectiveness, and initiation of billing by some clinics, 10 clinical sites retained their Health Educator beyond the Grant through budgeting the position into its next fiscal year of operations. To our knowledge, this is

the largest number of sites continuing among the SBIRT State Grantees. There were several ways that WIPHL promoted sustainability of SBIRT:

- Initially hiring Health Educators with appropriate aptitude, disposition, and traits which are associated with successful integration into the healthcare team
- Equipping those Health Educators with the knowledge, skills, confidence, protocols, and tools to provide effective services, to garner patient satisfaction, and to establish their credibility among the rest of the healthcare team
- Communicating the benefits of SBIRT to site administration, management, providers, and staff
- Assisting sites in designing and refining workflows that maximized SBIRT services delivery without hindering patient flow
- Assisting sites with billing for SBIRT services and resolving denied claims

More detailed information about sustainability can be found in *Wisconsin SBIRT Sustainability Plan Update, July 2011* (see **Attachment 10**).

Goal 7: Patients who receive referral to treatment, brief treatment, and brief intervention services will manifest a 25% decrease in days of risky alcohol use or illicit drug use.

Delivery of SBIRT services made a substantial difference across several patient substance use outcomes. The WIPHL evaluation team conducted a pre-post study of several measures. All pre-study data was collected at the time of intake into services via tablet full screen. Then, between 5 and 8 months, follow-up interviews were conducted by telephone. To be eligible to participate in the study, patients must have had a positive full screen and had the last two digits of their social security number within a 10-point range as specified by SAMHSA to ensure randomization. A total of 1,099 patients met these requirements; consent was obtained from 874 patients (80%); and interviews were completed with 675 patients (77%). For completed follow-up interviews, the evaluation team made an average of 4.7 calls (range = 1-31; median = 3 calls). There were several challenges to successfully contacting patients for the follow-up. To improve this rate, the evaluation team manualized a protocol and implemented a process improvement plan. More detailed information can be found in the *Follow Up Manual* (see **Attachment 11**).

WIPHL patients showed the following selected outcomes:

- 21% decrease in risky drinking among females under age 65, from 84% at intake to 63% at follow-up
- 17% decrease in risky drinking among males under age 65, from 87% at intake to 70% at follow-up
- 16% decrease in overall binge drinking, from 87% at intake to 71% at follow-up

- An overall reduction in the number of days drinking alcohol during the past 30 days, from 7.79 days at intake to 6.24 days at follow-up
- 5% decrease in marijuana use in the past three months, from 28% at intake to 23% follow-up
- At follow up, 65% of patients reported that the WIPHL program helped them to change or modify their lifestyle and 94% reported that they were currently working on continuing these changes

These reductions represent statistically significant and clinically meaningful outcomes. Of note is that the magnitude of reduced risky drinking found for the sample of WIPHL patients is comparable to the results of alcohol interventions in randomized clinical trials. Furthermore, a 20% reduction of risky alcohol use is associated with reductions of 20% in emergency department visits, 37% in hospitalizations, 46% in arrests, and 50% in vehicular crashes.[5] WIPHL's mission to improve the lives and health of Wisconsin residents was realized in this Grant. Detailed information about service outcomes, evaluation methodology, and interpretation of findings can be found in the *Final Outcomes Report* (see **Attachment 8**) produced by the WIPHL evaluation team.

Goal 8: WIPHL will generate policy-relevant data on penetration, volume, patient satisfaction, and effectiveness of SBIRT services.

If SBIRT is to go to scale, what strategies need to be utilized and policies put into place? Several insights emerged from the WIPHL experience to suggest several directions.

- Integrating depression screening into SBIRT can be feasible and effective. During Year 4, WIPHL obtained permission from SAMHSA to launch a depression screening pilot. Three clinics added the Patient Health Questionnaire brief (PHQ-2) and full (PHQ-9) screen to their screening protocol. A total of 1,356 patients underwent screening: 300 showed a positive PHQ-2 screen; 158 completed a PHQ-9 screen (scored 0 – 27) and 68 showed PHQ-9 scores at or above the clinical cut point (i.e., score of 10 or greater). Of the 68 patients with clinical level scores, 29 patients consented to participate. During the next 8 to 12 weeks, patients engaged 2 to 4 collaborative care and protocol-guided behavioral activation sessions with a WIPHL Health Educator. For follow-up, the WIPHL evaluation team was able to reach 22 of the 29 patients and re-administered the PHQ-9 screening in a phone interview. Mean PHQ-9 scores declined by 55%, from 17.1 to 7.7 ($p < .0001$) and 13 of 22 patients (59%) met successful treatment outcome criteria (i.e., PHQ-9 score reductions of 5 points and final scores of less than 10). Although this was a small pilot

[5] National Business Group on Health. Moving Science Into Coverage: An Employer's Guide to Preventive Services. Alcohol misuse (screening and counseling), updated 1/31/11. http://www.businessgrouphealth.org/preventive/topics/alcohol_misuse.cfm.

study, results suggest that bachelor-level Health Educators with no prior mental health training can effectively identify and engage depressed patients, in addition to substance use, within SBIRT services. More details of the pilot study methodology and results can be found in the manuscript *Employing Paraprofessionals to Deliver Depression Screening Services* (**Attachment 12**).

- Comprehensive behavioral screening and intervention (BSI) carries greater perceived value than just SBIRT and will therefore generate more sustainability and expansion in service delivery. BSI includes screening, intervention, referral and follow-up for tobacco use, unhealthy drinking, illicit drug use, depression, poor diet, obesity, and physical inactivity. BSI generates a more favorable perception among providers, payers, and purchasers than the more narrowly focused SBIRT because unhealthy and risky behaviors in general are responsible for a much greater proportion of deaths, chronic diseases, and healthcare costs. Furthermore, it is not uncommon for providers to regard tobacco use and depression as more important and more feasible to address in clinical settings than drinking and drug use. From the WIPHL experience in the depression screening pilot, it was clear that promoting BSI as a package will generate more service delivery than promoting SBIRT alone.
- There is an important case to be made that the Health Educator becomes an essential member of the health care team, as argued in Brown, R. L. (2011). Configuring health care for systematic behavioral screening and intervention. *Population Health Management, 14*(6), 299-305. Current healthcare providers simply do not have the time to deliver BSI services. However, utilizing Health Educators is feasible and effective. As documented by the WIPHL evaluation team, patients showed substantial reductions in alcohol and marijuana use after participating in Health Educator-guided services.
- One contributing factor of Health Educator effectiveness was likely in the allocation of resources and attention given to training and on-going learning. WIPHL maximized quality of services by providing skills-based training, tests of knowledge, and an on-going robust learning process (see **Figure 2**). An infrastructure was developed to help Health Educators achieve basic proficiency in Motivational Interviewing (MI) and develop cultural competency. Health Educators participated in weekly group conference calls, monthly individual reviews of audiotaped practice samples, including performance-based feedback and one-to-one phone-based coaching, and attended semi-annual retreats to celebrate successes and continue learning.
- A possible mechanism driving the patient substance use reductions may have been patient acceptability of SBIRT and satisfaction with services. During Year 3, WIPHL examined patient attitudes toward discussing alcohol and drug use with their Health Educator. Anonymous surveys were administered to 346 patients and using a 1(strongly disagree) to 5(strongly agree) response scale, patients made ratings on 4 items adapted from the Working Alliance Inventory (WAI)–Goals Subscale. As shown in **Table 3**, patients reported high levels of positive and constructive therapeutic relations with

Health Educators. These findings are notable given that patients were not expecting to discuss their use of substances during the healthcare visit. Prior studies show that high WAI scores are associated with better psychotherapeutic outcomes. On-going learning of MI and cultural competency likely increased Health Educators' ability to have respectful and collaborative conversations with patients; patients' subsequent experiences of satisfaction likely contributed to positive behavior changes.

Table 3. Patient satisfaction of Health Educator-guided SBIRT services.

Item	Mean Rating
What I am doing or have done with my health educator has given me new ways of looking at my drinking or drug use	4.27
I feel that the things I am doing or have done with my health educator will help me to accomplish the changes that I want.	4.24
As a result of these sessions I am clearer as to how I might be able to change my drinking or drug use.	4.27
I believe that the way we are working with my drinking or drug use is correct.	4.45

- An analysis by the WIPHL evaluation team of Health Educator education showed that bachelor's-level Health Educators attained greater reductions in patients' risky drinking compared to their master's-level counterparts. Possible reasons, observed informally, may be that individuals without prior clinical training more easily learned MI and delivered the brief intervention with greater fidelity, and that master's-level individuals felt too constrained focusing only on specific target behaviors rather than broader psychosocial concerns. The decision to employ bachelor's-level Health Educators without prior clinical experience should take into account the need for intensive training, support, and on-going monitoring to ensure delivery of high-quality services.
- SBIRT works with a variety of populations. The WIPHL outcome study showed that all but one patient population examined responded favorably to SBIRT in terms of positive substance use change. Patients who were age 65 or older did not show pre-post changes in alcohol use. However, SBIRT appeared to be effective with the youngest population. With SAMHSA's approval in 2009, a pilot was developed and implemented to deliver SBIRT with adolescents. The pilot involved screening 166 adolescent patients. For the outcome evaluation, 24 consented to follow-up, 12 were eligible for follow-up, and 5 completed the six month follow-up. Results showed significant reductions of substance use. Moreover, the teen patients had favorable impressions of the service and rated working with their Health Educator at a high level of satisfaction (see **Attachment 13**, pp. 27-33). These results should be interpreted with caution given the small sample size,

however, the pilot study results are consistent with a growing literature that shows SBIRT to be highly effective with teens presenting in opportunistic settings such as primary care, schools, and juvenile justice.

Goal 9: WIPHL will elicit commitment from major private and public health care providers and financers to systematically provide SBIRT services to its patients and subscribers by 2011.

A growing number of payers are reimbursing for SBIRT in Wisconsin. Despite significant budget pressures, DHS is maintaining Medicaid reimbursement for SBIRT under HCPCS codes H0049 and H0050. Medicaid reimbursement is completely compatible with WIPHL's criteria for "effective reimbursement." Additionally, WIPHL's Claims Submission Tracking Program showed that 19 commercial health insurance providers reimbursed at least one SBIRT claim each under CPT codes 99408 and 99409.

Table 4. SBIRT delivery revenue projections.

Billable services per day	Hours per day	Annual revenue ($)
10	3.5	86,417
12	4.3	103,701
14	5.0	120,984
16	5.7	138,268
18	6.4	155,551
20	7.1	172,835

To help provider organizations consider the creation of a Health Educator position, WIPHL made revenue projections based on reimbursement rates from commercial insurance (see **Table 4**). The calculation assumed that the Health Educator would deliver alcohol, drug, and tobacco screening and intervention services (alcohol, drug, and tobacco claims may be submitted for the same patient). Revenues from Medicaid, which uses HCPCS codes, are slightly higher, because commercially implemented CPT codes disallow claims for services of less than 15-minute duration. The major expense for clinics is Health Educator compensation and benefits which can approximate $60,000. Other expenses include ongoing Health Educator support and retraining in the event of turnover. Depending on whether overhead expenses are considered, the break-even point is 10 to 12 services per day – a much lower volume of service delivery than expected of primary care providers. The projections clearly indicate that revenue generated through systematic SBIRT delivery can fully support a dedicated, full-time Health Educator position, in addition to providing a modest level of profit.

Although WIPHL has succeeded at generating reimbursement from most payers in Wisconsin, WIPHL is finding that the availability of reimbursement is necessary but not sufficient to induce most healthcare settings to hire Health Educators to deliver behavioral screening and intervention. Other barriers are administrative overload and change fatigue among healthcare providers. Even though many healthcare setting leaders agree that behavioral screening and intervention services should be administered, they are already overwhelmed by the demands

of installing and refining electronic medical record systems, meeting meaningful use standards, administering other quality improvement initiatives, generating data for various quality measures, and addressing day-to-day stresses of managing complex operations. Therefore, WIPHL continues to promote uptake by:

- Educating providers on how systematic behavioral screening and intervention can help them meet Patient-Centered Medical Home recognition criteria and perform better with regard to various quality measures,
- Educating current and prospective accountable care organizations on how systematic behavioral screening and intervention can help them meet relevant quality measures and generate shared savings,
- Educating healthcare purchasers (employers and local governments) on the benefits of behavioral screening and intervention and promoting demand for it, and
- Promoting development and adoption of more rigorous quality measures around behavioral screening and intervention and of financial incentives to perform well on such quality measures.

Summary

Although the SBIRT service is relatively simple and straight-forward, systematic implementation with fidelity is anything but easy. In this Grant, 33 health care clinical sites participated and 52 Health Educators were trained. The Health Educator service delivery model was feasible and effective. Once initial training was completed, on-going learning, monitoring, and support for the Health Educators was critical to maximize success. Focusing on the development of Health Educator Motivational Interviewing skills and cultural competence likely contributed to the high satisfaction ratings by patients. Rates of screening improved over time as WIPHL improved its processes and protocols. Patients who participated in the outcome study (N = 675) showed a 20% reduction of risky alcohol use, which on a population level translates into substantial reductions of emergency department visits, hospitalizations, arrests, and vehicular crashes. Notably, 10 clinics continued providing SBIRT services at the conclusion of the Grant. Although a growing number of payers are reimbursing for SBIRT in Wisconsin, there is a long way to go in generating interest among provider organizations. One useful in-road to increasing uptake may be through involving the purchasers of health care, such as employers and local governments. In sum, WIPHL replicated what many other state grantees found: SBIRT can be efficient and effective, and it likely saves money and lives.

APPENDIX

ATTACHMENT 1 – WIPHL Word sample issue

ATTACHMENT 2 – MA Forward Health Update, description of SBIRT benefit

ATTACHMENT 3 – SBIRT Billing, Coding, and Reimbursement Manual

ATTACHMENT 4 – Final Program Evaluation report

ATTACHMENT 5 – MITI Results Graph template

ATTACHMENT 6 – Referral to Treatment materials

ATTACHMENT 7 – Process Evaluation report

ATTACHMENT 8 – Final Outcomes report, August 2012

ATTACHMENT 9 – Clinic Guide and Checklist

ATTACHMENT 10 – Sustainability Plan Update

ATTACHMENT 11 – Follow Up Manual

ATTACHMENT 12 – Depression pilot manuscript

ATTACHMENT 13 – Preliminary Outcomes report, March 2010